reality and reeducate him to view his symptoms as the outcome of his mental reaction in an adult world and lastly to emancipate the patient from the transference to the analyst.

Word Association.

This is another method introduced by Jung of investigating the working of the unconscious, and of unearthing repressed complexes. It is done as follows. The patient reclines in bed or on a couch and is told to relax mentally in the same way as that adopted for free association. The physician sits at the head of the bed behind the patient and from a printed form calls out a list of words one at a time. The patient is told to reply to each word he hears uttered with the first word or idea which comes into his mind. The time taken by the patient to reply to the stimulus word is measured by a stop watch and recorded, along with the reply, by the physician. About 200 to 250 words are used ordinarily so that the whole test takes about two hours to complete. The normal reaction time is usually two seconds. In compiling the list of words to be used in the test it is essential to select about 30 or 40 words which have a definite association with the patient's illness as well as with his life history. By noting the length of time taken to reply as well as the nature of the reply given, it is possible to detect the existence of a "complex" of some significance in the etiology of the malady. On the completion of the test it is repeated over again in the same manner as on the first occasion and differences in time reaction and word reaction noted.

The following are the indications that a complex has been touched or disturbed. Jung terms these as 'complex-signs'.

(1) Delay in reaction time. A gross delay is due to some emotional disturbance.

(2) Failure to respond. Nil-Association is a form a resistance.

(3) Senseless reaction. This is equivalent to a refusal to answer by 'changing the subject'.

(4) Anomalous superficial reaction. Repeated clang associations are suspicious especially if there is unusual delay.

(5) Repetition of the stimulus-word.

(6) Repeated use of the same answer.

(7) Uncommen and unusual reaction. The answer to the stimulus may be extraordinary or bizarre.

(8) Misunderstanding the stimulus word or he may answer by asking for an explanation or by using a long phrase-a sort of memory screen.

(9) Defective reproduction. At the end of the test when the reactions are checked once again the patient may either have forgotten the previous reaction or that he was ever given the particular stimulus word or he may give a different incorrect reproduction the second time. These are further indications of the nature of a complex.

The practical value of this method is that it is of help in the diagnosis of the mental disorder, as a preliminary to psychoanalysis or where this is difficult, as in the case of children or ignorant persons. For the training of beginners in psychoanalysis this method is excellently suited.

Mental Mechanisms.

The following terms are generally met with in psychoanalytical literature and are here explained.

Abreaction.—The process of recalling and living through again in imagination a forgotten painful experience and giving vent to or discharging the emotion or feeling associated with it. The common expression "get it off your chest" aptly describes this process—

Affect. Emotion or feeling tone which accompanies all activity and thinking,

Ambivalence—The coexistence of opposite feelings e.g. love and hate.

Anal erotism—Pleasurable excitation derived by stimulation of the anus. From the memory of this infantile experience there develops later certain character traits such as orderliness, parsimony, irritability and self-willedness. Freud maintains that these are all the result of infantile interest in the process of defeca tion.

Castration complex—The idea of injury to the genitalia rising from the memory of parental threat of injury as a punishment.

Catharsis—The purging of or discharging the effects of a pent up emotion by bringing it into consciousness.

Conversion—The changing of a repressed idea (usually) into a physical symptom or disability. This is usual in hysteria. It is a form of simulation. An example of the conscious counterpart of the same process is when a school boy develops a headache or colic just when it is time for school.

Dissociation. A process of splitting of the personality into subsidiary parts, controlled by interests which hold sway for a time. Mental processes are dissociated, split off from consciousness, kept repressed in the "unconscious," either when they themselves are incompatible or else when they are closely related.

Displacement The transference of affect from one idea to another

Fixation The arrest or anchoring of interst (Libido) at a particular stage in the sexual development.

Libido Sexual energy or impulse and its ramifications. In the Freudian sense it is the energy love of the instincts but to Jung it is psychic energy in general.

Oedipus Complex—The unconscious desire to kill the father and possess the mother.

Narcissism Self-love. A stage of sexual development where all the interests are centred on oneself i.e., autcerotic. The object is still the self and not yet another person.

Projection The ascribing to the outer world, ideas that are not recognised to be of personal origin. Hallucinations and delusions are morbid ideas externalised by the patient, in his environment.

Rationalisation—The inventing of a reason, an explanation, for an idea or action, the origin or motive of which is not recognised.

Repression The inhibition or keeping down in the unconscious of ideas that are painful to or in conflict with the conscious ego.

Regression The turning back to an earlier period of development and thus to obtain gratification there. A form of flight from reality.

Sublimation The carrying over or deflection of interest from prohibited ideas or activities into those that are socially permissible or useful. A means of overcoming repression in a more or less normal way.

(c) **Care of the incurables.**

When may a psychotic patient be said to be incurable? If within five years there is no improvement the condition is probably chronic. Even then one cannot say with any certainty that recovery will never take place. The majority of patients after a residence of five years passes into a state of gradually progressing dementia, but there are nevertheless several instances on record where apparently incurable cases have made a dramatic recovery. Even in cases of dementia praecox where the outlook is most unfavourable it is possible with modern methods of therapy to expect an arrest of the disease if not a remission. The case of the lower grades of aments, idiots and imbeciles is different, and the term "chronic" is inappropriate to them as nothing can be done to replace a mental faculty that is wanting.

The majority of chronic patients in an institution are by nature docile, childish, harmless, apathetic and demented but fully adjusted to hospital life and apparently contented and happy. They have been trained into the routine of ward life and are usually amenable, helpful, and well-behaved. Hence they do not require the same amount of close attention from doctor or nurse, as they did in the beginning. However, all chronic patients should be examined mentally and physically at least once a quarter or half yearly and notes made on their condition. Every

attempt should be made to preserve their physical health at its best. Owing to the expense to the state of maintaining such patients for many years, every attempt should be made to induce visiting committees to discharge entirely or on parole those who can be cared for at home by friends or relatives. Those patients who have a pension or other private income might well be boarded out, with persons willing to undertake the charge of insane patients at nominal rates. The care of most of these chronic patients lies in the hands of the nursing staff and chiefly consists in disciplining them to regular habits of life. Many are able to look after themselves but some require constant attention in regard to food, toilet, work, play, rest, correction of bad habits mischief or prevention of accidents. Many patients can be made to assist in ward work, in the pantry, bedrooms, general kitchen, in the gardens etc. when not employed at the Occupational Therapy department. If neglected many of these patients eventually become helpless, dirty, slothful and even troublesome. The nurse should continually try to cultivate those interests and activities in each patient which tend to lead to the reestablishment of normal habits. Here it may be emphasised that the more a mental hospital is bereft of any prison element and the more it approximates with home life the better will it be for the happiness and health of every patient in it.

SUICIDE AND ITS PREVENTION

Suicide is the perversion of the instinct of self preservation. It is man's great retreat from life and constitutes a final regression from reality when he is unable to endure suffering in the present or pain in the future. Federn holds the extreme view that suicide is perhaps the final act of a perfectly normal person, but there is much truth in the lay verdict of a coroners jury, except in very exceptional cases, that the suicide was "temporarily insane". There can be no doubt that from whatever aspect we view this problem a psychological study and investigation of the subject will reveal the best results. Suicide may be accidental, intentional or impulsive, and it may occur in a state of sanity or insanity. The subject demands the closest attention of psychiatrists, the general practitioner, the social workers, in this country as well as internationally, to discover some means to prevent it or at least reduce the apalling numbers which occur annually. The statistics on suicide make most alarming reading. It is estimated that sixty cases of suicide are reported daily in Germany. In New York and its suburbs there occur about 1,600 suicides a year and about an equal number of attempts at suicide. The rate per 10,000 of the population stands at 4.2 for Berlin, 5.1 for Hamburg, 5.8 for Vienna, and 2 for New York. San Diego, California, has the highest suicide rate in the United States. In 1929 there were 1983 suicides in England and Wales. Bond, reviewing the statistics in England and Wales for the past 49 years, finds that the ratio for all ages per 10,000 of the population is 1.4 for males and 9 for female and that there has been a slight rise in the last decade. The sex proportion is about 3 males to 1 female. However accurate these returns may be they do not represent the full incidence of the suicide rate nor that of attempts. Although numerous superficial causal factors of suicide have been advanced, the great majority

of the cases of suicide are definite expressions of failure of adjustment to life, hence suicide is now anything except an expression of definitely pathological maladjustment whether to oneself, to others or to the economic world. Depression or a wish to escape from insuperable difficulties is usually quoted as the prime cause, but reviewed psychologically there must be deeper motives. These are (a) **self-punishment**. The sense of guilt is often a motive for self-punishment. This can be observed in the feeling of guilt evoked in some persons by masturbation especially when masturbation is resumed after it had been discarded for a considerable time. Unrequited love likewise may evoke a desire to punish which may lead to suicide but here the underlying motive is not so much to punish oneself as to punish the other party by arousing in him (or her) a life-long feeling of remorse. Such forms of suicide are therefore in reality a kind of murder.

(2) **Frustration of the sexual instinct.** Both men and women commit suicide on account of homosexuality. Hirschfeld estimates that 3 per cent of all suicides are inverts. Conflicts over these tendencies in themselves, fear of social discovery and the sense of inferiority for not being as others, is a strong motive. Exhibitionism as well as impotency are equally strong aetiological factors. The double suicide of lovers is a symbolical gesture of attaining a "perpetual honeymoon" by dying together. The practice of burial in the family vault or in or near the grave of a partner is a conscious counterpart of the same idea. The origin of "Suttee", once prevalent in India, is traceable to a primordial virginity taboo and not to the idea of self immolation.

Among childless and unmarried women suicide is three times more common than among mothers and married ones. In

the case of the unmarried mother, social disgrace is the main cause.

(3) **Physical pain**—Pain that is unendurable and prolonged whether from disease or other causes drives the sufferer to seek relief in death. The pain of tic-dolereaux, incurable tumours as sarcoma and carcinoma and wounds in the head, account for some cases of suicide. The fear of insanity is also a common cause. In the pre-psychotic stage a strong suicidal tendency may resolve itself when the psychosis is fully developed. The analytical explanation of this fear is that the repressed unconscious conflict may break through into awareness and expose the underlying guilt complex. Should guilt have its source in hostile wishes we can understand how closely homicide and suicide are related and in fact often closely follow one another.

In extremes of hunger and thirst but more especially the latter, suicide is resorted to.

(4) **Social sufferings and fears**:— Bankruptcy, dismissal, exposure of fraud or misdemeanour, bringing ruin and social ostracism in its train are the simpler motives for suicide in men. Among women illegitimate pregnancy is probably one of the chief causes of suicide. In India a high percentage of suicide occurs among girl wives who are harshly treated by their mothers-in-law and husbands.

Regression—Freud has formulated the hypothesis that there is an innate "death instinct" which urges us to a state that is free from tension and responsibility. Thus there is a deep connection between suicides and certain extreme degrees of mother-fixation, a state of "nirvana" that is coveted. In the young, too much love from the parents renders the individual so greedy of affection that he is incapable of living without it in later life.

Sometimes the suicide is Messianic in character. The self imposed fasting by persons for political or social reformation is of the same nature. From the stand point of religion the lowest rate is among Roman Catholics and the highest among Protestants. This may in part be due to the great satisfaction the church of Rome affords to the mother complexes of man-kind. The Jews are rated between the two sects.

The psychoanalytic conception of suicide is well summed up in Freud's words "probably no one finds the mental energy required to kill himself unless in the first place he is doing this, at the same time killing an object with whom he has identified himself, and in the second place is turning against himself a death wish which has been directed against someone else. The unconscious of all human beings is full of such death wishes even against those we love". Meninger, in his analysis of suicide, sees in it a particular kind of death having three distinct elements for each of which there appears to be always unconscious and sometimes conscious motivation in (1) the element of dying (2) the element of killing (3) the element of being killed.

The legal aspect of suicide or of attempts thereto, is that it is a crime and is punishable. Though legal enquiry may be necessary it is very doubtful whether any good results follow from regarding suicide, actual or attempted, as a crime.

There is no doubt that a good deal can be done to retrieve unfortunate persons with these awful propensities. The incidence in large cities can be definitely reduced by the formation in each of societies or bureaux to assist those who contemplate or attempt suicide. Pastors, Teachers, Doctors, social workers and even the Government should be invited to form centres where help, advice, encouragement, psychiatric investigation and treatment can be

given to re-educate, re-adjust and reform these unfortunates. Publicity should be given to the existence of such centres where people can apply for help. Police, coroners and magistrates could help by referring all cases brought to their notice, to the Bureau. It is to the credit of the Salvation Army, that it is the one body that has done the most for the prevention of suicide in many countries. Journalists and the lay press could assist a good deal by refraining from reporting the sordid details of cases and thereby stem the abnormal interest that this type of sensational news attracts.

As regards psychotic individuals, suicide is a common and often constant symptom in melancholia. It is also found in alcoholism, epilepsy, anxiety states and chronic hallucinatory psychosis. Opinions are divided as to whether psychoneurotic individuals are potentially suicidal. Whatever the condition is, it is important to recognise the symptoms at the earliest possible moment.

A fallacious idea, common in medical minds, is that if any individual talks of suicide he will not carry it out. It must be remembered that if the emotional idea is strong enough it will be carried over into overt action. In mental hospital practice however one has ever to be on the alert not only to detect symptoms but to prevent all possibility of the achievement of suicide. This means constant supervision at all times. Melancholics specially should never be left unattended. They will plan and wait silently for the first opportunity that presents itself when they are alone. There is no need for restricting liberty of movement or depriving him of every possible instrument or article that may be used. If a patient is determined to die and has nothing to kill himself with, he may even resort to dashing his head agaidst the wall or floor. Close and constant attention therefore is the best preventive. Even in the stage of convalescence, vigilance must not be

relaxed. Searching a patient for contraband may at times be necessary but it must be done tactfully. In private practice the physician should insist that a case of potential suicide has at least three reliable attendants, to watch him day and night.

CHAPTER XIV

Mental Hygiene.

The name of Clifford W. Beers will be for ever associated with the mental hygiene movement which he started in 1909 with the establishment of a National Committee for Mental Hygiene in the United States. Since then the movement has spread the world over and most countries have their associations. To another layman Captain H. Stedman of the Indian Army is due the formation of the Indian Association of Mental Hygiene.

Mental Hygiene deals with the principles of mental health, that is, the importance of mental health as a factor in the efficiency of the individual whether in the familial, school, industrial or social circle. In all departments of medicine more attention is being given to the early manifestations of disease with a view to prevention. As in medicine in general, more attention is now being given to the preventive aspects of illnesses, so in psychiatry, the early diagnosis of symptoms of mental disorder is becoming more and more imperative, for the same reason: The wisdom of the dictum "Diagnosis preceeds Treatment" should be as evident in psychiatry as in any other branch of medicine. Just as antenatal clinics, clinics for children and for the diagnosis of tuberculosis exist to prevent or arrest physical disorders so psychopathic clinics are concerned with the arrest of mental disorders in their early stages. The function of a psycho-pathic clinic is well summed up by the National Committee for Mental Hygiene, in whose prologue we read as follows:—

"This committee directly and through its affiliated state societies and local committees, work for the conservation of mental health, the reduction and prevention of mental and nervous disorders and defects, the improved care and treatment of those

suffering from mental diseases, the special training and supervision of the feeble-minded; and the acquisition and dissemination of reliable information on these subjects and on mental factors involved in the problems of education, industry, delinquency, dependancy and others related to the broad field of human behaviour. The Committee seeks to accomplish its purposes by stimulating research into the nature of nervous and mental diseases and defects, conducting surveys and studies of mental hygiene problems; applying the knowledge gained from such studies, through education and the promotion of beneficial legislation; encouraging psychiatric social work, establishing child guidance and other mental hygiene clinics; developing trained personnel and co-operating with Government and unofficial agencies whose work touches at any point the field of mental hygiene. When one considers the large group of people who may be benefitted by organised work in mental hygiene, the importance of the movement at once becomes apparent. Such work is not only for the mentally disordered and those suffering from mental defect but for all those who through mental causes are unable so to adjust themselves to their environment as to live happy and efficient lives". As a movement therefore, it concerns itself with the study of the mental aspects of various social problems and their satisfactory solution. An important part of the work of any mental hygiene scheme is the breaking down of the common prejudices and superstitions in regard to mental illness and the education and enlightenment of the public in the recognition of the earliest signs of mental unbalance. Only when the ability to recognise these early signs of mental disorder is more wide spread can we hope to see the general public anxious for advice and treatment. Thus, one of the most important functions of the mental hygiene movement is to encourage the spread of this knowledge and so

prevent the progressive development of symptoms until the certification of the patient becomes inevitable.

Mental Hygiene, like Medicine, is an art rather than a science and its technique is derived from the techniques of medicine, psychiatry, psychology, education and social welfare work.

All who have to do with the problems of human behaviour like the nurse, the parent, the teacher, the minister, the physician and above all the pediatrician the lawyer and the crimonologist, have each an important role to play in the drama of mental hygiene. Just as we practise the simple laws of ordinary medical hygiene from childhood, Mental Hygiene should begin from one's birth.

Child Guidance Clinics—The establishment of these clinics in every large city should be one of the first activities of every national committee. It should form part of an out-patient department of every children's or General Hospital: Here problem children are brought for advice and treatment for the correction of some abnormal behaviour or personality trait. Intensive study of the child is undertaken in the hope that not only may such nervous symptoms as enuresis, shyness, backwardness, temper tantrums, stammering, etc. be properly dealt with, but that other behaviour characteristics may be checked from developing into a neurosis or even a psychosis at a later age. Dr. White's dictum "childhood is the golden age for mental hygiene" is as true as the old saying "train a child the way it should grow". In the upbringing of children there are many factors which play a notable part in their progressive mental development. Among such we may take note of heredity, the home, family jealousy and parental behaviour, as well as the diabilities attendant on physical handicaps,

The next fertile field for mental hygiene is the school. The average school teacher pays more attention to teaching the three R's than to the study of the personality of the pupil. If a child is timid, dull or diffident it may be neglected or it strives to keep up in class in spite of its handicaps and the whole of school life becomes a drudge instead of a pleasure. In the school there are a number of problems which lie within the province of the psychiatrist. Failure to maintain the average grade may be due to a number of factors other than mental defect. The child may be retarded because of malnutrition, insufficient sleep, dislike of a subject or of the teacher, or on account of other neurotic symptoms. The school in cooperation with the home should clear the way by helping the child to realise his good points, develop and encourage his interest and abilities, make it possible for him to face his weaknesses and disabilities without shame or a feeling of inferiority. The big problem of the high school period is ordinarily recognised to be that of sex, for here the pupil is passing into the unstable age of adolescence. Now, interests in sexual activities are increased, active masturbation commences and may lead to other perverse activities. The modern view is that boys and girls at this period should be enlightened on sex and taught sex hygiene, but opinions on this point are still very much divided. It is not so much the subject as the manner of enlightenment that counts. An appeal should be made to the ethical moral and religious codes of conduct. Never punish or threaten a child that has masturbated. A few words of kindly advice and cautious enlightenment will be of far greater value in reforming a child. Punishment produces more shame, guilt and fear. To tell a child that masturbation will produce horrible diseases, insanity or feeblmindedness or to threaten to cut off its sexual organs is positively criminal. The seeds of a neurosis are thus sown and may become

manifest in complexes about castration, the "unpardonable sin", eternal damnation, inferiority, etc. The earliest changes as the result of such injudicious correction are irritability, shyness, seclusiveness and day dreaming. More serious are the effects on the personality. The child feels that he is different from others, no good, wicked etc. Conflicts over sex are prominent factors in the causation of nervous and mental diseases. Desires and inhibitions are continuously at war. Most people adjust themselves gradually but many who are emotionally unstable fail.

Another problem of childhood and adolescence is that of delinquency. This is a subject for investigation at child guidance clinics or early treatment Centres. The modern trend is to look upon crime as a disease and not as a characteristic or vicious propensity. Hence the underlying causes of crime must be investigated from the psychological stand point, if we are ever to control or prevent it. Numerous factors are the basic causes of crime which is simply an abnormal form of behaviour and represents an individual's struggle to attain a goal as a compensation for some inadequacy, physical or mental. Mental defect accounts for a large percentage of delinquency, but so also may physical defects such as obesity, speech defects, undersize or being inferior or different to others. All these factors contribute singly or in combination to attain some compensation to the individuals feeling of inferiority through the perpetration of a criminal act. Economic factors, desertion of parents, failure to achieve a healthy emancipation from parents, repressive discipline, are some of the causes of delinquency in children. The incidence of delinquency increases as one goes down the economic scale. A recent investigation of the endocrine functions of habitual criminals has revealed the fact that three times as many criminals suffer from

endocrine imbalance as the normal average population and that the majority of these are juvenile delinquents. A large proportion of adult crime grows out of our failure to handle successfully and constructively the juvenile offender. The best approach to the study of Juvenile Delinquency is the study of the psychic factors at work in each case, an approach that is necessary not only in our juvenile courts but in the class room, the home, and all other community organisations that deal with the child. This approach has a threefold character. In the first place it is medical that is to say, every possible medical and psychologico-medical factor in the case is subjected to strict investigation and all errors put right immediately. Secondly a psychological investigation is carried out in order to determine by Binet-Simon tests, performance tests, and by tests for special abilities to ascertain, any degree of feeble mindedness. Thirdly, the investigation is not complete without a full sociological survey of the home and the environment in which the child has grown up.

In such child guidance clinics not only are numerous disorders of physiological and psychological functions corrected but the symptoms of incipient criminality nipped in the bud before they blossom into chronic delinquency. The scope and functions of juvenile courts is discussed in the chapter on medico legal aspects.

Psychiatric clinics. The incidence of psychoneurosis of various types, conduct disorders, delinquencies, mental defect and incipient psychoses in the general community is vast and if such persons could be helped in the early stages, by attention to the early symptoms the ultimate relief and happiness to the sufferers and boon to the state would be enormous. The primary aim of the clinic should be the restoration of the greatest possible number

of people to health and social efficiency in the shortest possible time. These clinics should form part of the out patient department of every general hospital and mental hospital. Here opportunities for medical practitioners and students will be provided to gain experience in psychotherapy but more especially to recognise the early signs of any mental abnormality. The clinic will also be a centre for research and the prevention and cure of so-called "nervous" disorders.

The staff should consist of a team of workers comprising a psychiatrist, who does the physical as well as the mental examination, a psychologist who does the special intelligence tests, Binet-Simon performance and educational tests, and one or more social workers. A physical examination of the most careful and thorough type is needed for the elimination of foci of infection or the detection and correction of some physiological or endocrine trouble. On the mental side, the analytical method of approach is essential, and as the aim of the clinic is to provide a consultation service for diagnosis and advice it should adopt a broad Catholicity by embracing the methods of the schools of Freud Jung and Adler. When attached to a General Hospital, it would be advisable to have in addition to this out-patient clinic, a small ward set apart for the admission of selected cases on a Voluntary basis, for observation and treatment. The benefits of such a ward are obvious and it will also serve as a clearing station to a mental hospital when occasion arises. A small nominal fee should be charged to all cases that attend the clinic and it will be preferable to have late afternoon or evening sessions in order that patients who are at work and should, if possible carry on their daily occupations, may find time to attend. As to equipment very little is needed and the most satisfactory plan is to start on a small scale with an ordinary consulting room with the bare necessities

in the way of furniture. An adjoining waiting room and a small office would be an advantage. No elaborate apparatus or appliances are necessary and there is no need to waste money on delicate instruments that are found in a laboratory of experimental psychology for obtaining data that are of doubtful help, when we are faced with the more important factors concerning a deranged personality.

This clinic should of course work in conjunction with the other departments of the hospital and mutual help obtained from one another.

It is essential that detailed history and case sheets should be kept for each patient and filed.

The existence of every clinic whether attached to a mental or general hospital or by itself should be made known to the public who should be enlightened and encouraged to take advantage of it at the earliest opportunity.

The utility of a psychiatric clinic may be summed up as follows:—

(1) It brings psychiatry and general medicine closer together.

(2) It provides unparalleled clinical experience for students and general practitioners if they care to attend it, for it is just such early cases that they will meet in general practice.

(3) It provides teatment for cases not ill enough to justify their admission to a mental hospital and yet who will not recover without some form of treatment.

(4) It paves the way for the enlightenment of the lay mind, on the subject of mental illness.

(5) It helps to reduce admissions to the state mental hospitals by arresting morbid mental processes before they advance into a serious illness.

CHAPTER XV

Medico-Legal Aspects.

There is no branch of medical science that is so much hemmed in by the law as psychological medicine and the basis of this great legal interest is that when a man loses his reason he must be protected against himself or against society. At an early period in England, the custody and control of the person and property of lunatics or idiots was vested in the King. The term "Lunatic" appears in the statutes for the first time in the reign of Henry VIII. From this was derived the authority to initiate an inquiry as to soundness of mind in a given case. This authority was delegated by the King to the Lord Chancellor as representative of the Crown by means of an official document, called the Sign Manual, which bore the King's signature and was sealed with the King's Privy Seal. The present mass of intricate legislation that has gradually evolved cannot be avoided inspite of rent reforms in the mental treatment bill and the study of psychiatry by the specialist or general practitioner must include the legal relations of insanity.

In India there is only one Act, the Indian Lunacy Act (1912) by which persons, whether suffering from mental disease or mental defect, are governed. Unfortunately, unlike other countries, India has not a Mental Deficiency Act, although so long ago as 1929 I drafted a Mental Defective's Act and submitted it to the Legislative Assembly. The undesirability of bringing persons whether mentally diseased or defective under the provisions of one Act and of subjecting them to care and control whether children or adults in the same institutions side by side is so obvious that no further comment is needed. The legal concept that "lunatic"

means an idiot or a person of unsound mind is wholly wrong. The main aspects of Forensic Psychiatry may be taken as follows :—

(1) Certification for Care and Control.
(2) Inquisition as to Lunacy
(3) Testamentary capacity
(4) Civil liability
(5) Criminal responsibility
(6) Juvenile courts.

(1) **Certification**—

Never certify a patient unless it is absolutely necessary. Certification should only be resorted to when a patient is unmanageable and requires care, control and treatment which can be best obtained in a mental hospital. It may be dispensed with in a patient who has ample means if he can be managed in his own home without any loss of liberty. The present trend however is to encourage voluntary admission. This does away with the bother, expense and delay of getting magisterial orders from a court, medical certificates and fees, escorts, and the publicity that attends certification. Voluntary patients may be admitted on making a written application to the Medical Superintendent, of a hospital. Such patients are at liberty to leave the hospital at any time after giving in writing to the Medical Superintendent 24 hours notice. Under Section 4 (2) of the Indian Lunacy Act, 1912 a voluntary patient may not be detained after the expiry of 24 hours notice. The Medical Superintendent reserves to himself the right to refuse admission to any person applying for admission as a voluntary patient. It may often happen that the relatives of a patient are desirous of avoiding the so-called "stigma" of certification, hence they bring him for admission as a "voluntary" patient in spite of the fact that the patient is not willing to be admitted or is in such a condition of mental disorder that even

were he to sign the Voluntary admission form he does not understand it. The patient is surely in need of treatment. In such cases the only thing to do is to admit the patient on the authority of the relatives who signs the admission form on behalf of the patient. This is sufficient to indemnify the Medical superintendent. If the law lags behind because there is no provision for this contingency there is no reason why psychiatry should follow suit.

Should a patient that has been admitted on a voluntary basis for the treatment of an early psychosis get worse and then apply for his discharge, there are only two lines open to the Medical Superintendent of a mental hospital. Either the discharge of the patient to the care of his relatives or an application on the part of his relatives to the local magistrate for a detention order under Section 16 of the Act. The patient can then be detained for periods not exceeding 10 days at a time or for a total period not exceeding 30 days to enable a medical officer to determine whether he is a person in respect of whom a medical certificate may properly be given. If the medical officer can certify the patient the magistrate issues a reception order on this certificate.

The same procedure is followed in the case of all persons found wandering at large and believed to be insane. Any police officer may arrest such person under Section 13 and 15 and produce him before a magistrate. Similarly if a person who is believed to be insane and not under "proper care and control" or if the relatives or friends are unable to control and care for him properly they may apply to a magistrate who can at once order the detention of such person in a suitable custody. All patients who are admitted under the above circumstances must invariably be accompanied by the following documents.

(1) A reception order of magistrate, attested with the Court Seal.

(2) One Medical certificate—one copy.

(3) Descriptive roll of a patient—one copy.

(4) Certificate of patient's fitness to travel —one copy.

Another method of admission is by a Reception order on petition.

Under Section 5 any relative or friend of a person who is suffering from mental disease and is in need of treatment in a mental hospital may apply for a reception order by making a petition accompanied by a statement of particulars relating to such patients. The petition must be accompanied by two medical certificates on separate forms or sheets of paper, one of which must be from a Government medical officer, and the other from a registered medical practitioner. The cost of transport of the patient to hospital is now borne by the relatives or friends. The following documents must accompany the patient.

(1) Petition for a reception order. 1 copy

(2) Two medical certificates

(3) Reception order on petition by magistrate, attested with the court seal—1 copy.

(4) An indemnity bond executed on stamped paper before a magistrate undertaking to pay the maintenance charges of the patient—1 copy

(2) **Judicial Inquisition**—"de lunatico inquirendo"

Any person found by Judicial enquiry to be insane and incapable of managing himself and his affairs may be admitted on the order by the High Court or District Court as the case may be on application made by any relative of such person for the judicial

enquiry. This is usually done in the case of a person possessed of lands or property which by reason of mental derangement, he is unable to manage or control. Under Section 7 of the Act the court usually appoints a manager to look after the property and estates of the insane person, the maintenance of his dependants and even the control and custody of the patient so long as he is not dangerous to himself or others. The manager may not mortgage, sell, transfer or lease any portion of the property without the permission of the court. The court as it thinks fit may apply the property for the maintenance of the patient, his dependants, payment of his debts, cost of enquiry etc. If later, the patient recovers and the court finds that his un-soundness of mind has ceased these proceedings in lunacy are ordered to cease.

Writing Medical Certificates—

This is done on a special form. It is essential that the greatest care must be exercised by a physician when asked to give a certificate. The majority of certificates received with patients are worthless as such, simply because practitioners are careless in the statements they enter.

When called upon to certify a person first get a detailed history from the relatives or friends. Next, interview the patient and engage him in conversation in a friendly way. Test his orientation in time and place, his memory for past and present events. his attention, judgement, ideation and emotion. Make notes of all he says or does and test if hallucinations or delusions are present. Do not fail to ask tactfully about the sex life, a wealth of information may often be obtained here.

The certificate consists of two parts :—

(a) Facts indicating insanity observed by you. Here confine yourself to actual statements of facts. These facts must be such

as to bear cross examination of the certifier in a law court. Indefinite or irrelevant statements, inferences and expressions of opinion should not be made. Do not make vague statements as "He looks stupid, worried or depressed" "He refuses food and is sleepless". "He is suffering from delusions of persecution or grandeur". If a patient says he is ruined or has committed some crime or accuses his wife of infidelity or that he is persecuted by some persons, some qualifying statement should be added such as "which is not the case" or "which is a delusion". The wording of a certificate should be explicit and free from technicalities. Certification is a legal process not a scientific one and the certificate has to be considered by a layman, the magistrate—

(b) Facts communicated by others:—

This part acts as corroborative evidence adduced by relatives or friends in the capacity of a witness of facts noted by them which **they consider** as signs of insanity. This portion may be left out if the certificate is strong enough. Most medical men however include it to reinforce the certificate. Although there may be a certain amount of fear and hesitancy on the part of medical men to sign lunacy certificates, as the responsibility rests on them—no responsibility rests on the magistrate who orders the detention:— there is some consolation in the fact that recent legislation in England protects the physician from any process at law for alleged wrongful certification. Only the High Court can order that proceedings be taken if it is convinced that there are sufficient grounds. These facts communicated by others must be recent. The certificate must be signed and dated by the physician and presented within 7 days along with the petition for a reception order. The certificate should not be signed by any person who is to have charge of the patient, neither should the

certifier have any interest in the property of or the payments made on behalf of the patient. In petition cases the two physicians must examine the patient separately and independently. Many medical certificates savour of collusion which is to be deprecated.

(3) **Testamentary capacity.**

The question of legal capacity arises more often in connection with making a will than in any other civil matter. A man may be insane to the extent of being a danger to himself or society, yet have sufficient mental ability to make a will. The power to make a **Will** is testamentary capacity. It is called into question when a particular Will is disputed. An idiot or imbecile by reason of his mental defect does not possess testamentary capacity. A Will made by a person alleged to be insane, though reasonable is usually set aside in equity. A sound Will may be made during a "lucid interval" and may be upheld by a court if it is satisfied that there was a complete recovery of sufficient duration to make a Will. A valid Will can only be made by a person equipped with what the law terms a "sound disposing mind". A doctor is sometimes called in to test this ability in a person about to make a Will. The relatives too may be more concerned to avoid later disputes.

The following points should be noted when doing this.

(1) That the testator knows the nature of his act and its consequences.

(2) That he knows the nature and extent of his property.

(3) The proportionate claims of his different relatives, who by ties of blood and affection are the natural objects of his bounty.

(4) That he is not under the undue influence of anyone or of any drugs.

(5) That his decisions are not influenced by any abnormality of mind, as delusions against a particular person etc.

(6) That after an interval he is able to recall the details of the Will.

Always keep complete notes of your examination for even years later you may be called as a witness at the Chancery hearing. When called in to examine a testator contemplating a last Will and testament, it is advisable to insist that the family solicitor or legal adviser is also called in consultation as a witness. If in doubt call in a colleague to assist and advise you. If a person commits suicide or develops insanity some time after the making of a Will, this does not necessarily reflect upon its validity. Even if questioned, the court usually upholds the Will. But a lot depends also on the finding of a jury who have to arrive at a verdict upon the facts before them and decide upon fine and intricate questions of psychology which may be most difficult to answer or have no answer at all. The average juryman is a total stranger to psychology, is distracted by conflicting evidence and is expected to decide, with the help of the judge, whether a man was sane, eccentric, fatuous or insane, at the time of making a Will. That some measure of reform in this legal sphere is called for is obvious and the equally obvious solution would be to appoint two expert alienists as assessors to a Bench whenever the testamentory capacity of a person is questioned in a dispute over a will.

(4) CIVIL LIABILITY.

The question whether the contract of an insane person is valid or void or only voidable, caused a good deal of difference of legal opinion during the last century but it is now practically settled that the contract of a person of unsound mind is voidable at his option if the unsoundness of his mind was known to the

other contracting party at the time of the contract. Just as in the case of a Will, a person in a "lucid interval", may make a valid contract, so also, a contract made before the onset of insanity is binding, but he must in the event of recovery elect within a reasonable time whether or not he desires to abide by the contract. The legal infant (a person under 21 years of age) however, whose intelligence is at most only limited, is treated much more considerately than the insane. If a merchant enters into a contract with a youth aged 20 who appears to be over 21, the former will have to bear the loss resulting from his mistake unless the goods supplied were "necessaries". An insane person however can during his insanity make a binding contract for what the law calls "necessaries" and this whether the other party is, or is not aware of the insanity of the former. The "necessaries" of life, for the patient and his family must be in keeping with his and their manner of living.

Persons drunk are in the same position as insanes with regard to their capacity of contracting. The contract of an intoxicated person is voidable but not absolutely void, therefore, it is capable of ratification by him on coming to his senses. When a person who is in a position to dominate the will of another enters into a contract with him and the transaction appears on the face of it, and on the evidence adduced, to be unconscionable, the burden of proving that such contract was not induced by undue influence shall lie upon the person in a position to dominate the will of the other. This sometimes happens when a girl is induced by her parents to marry a man against her will.

Loans, sureties and promissory notes.

The insanity of a borrower, unknown to the lender who acted fairly and in good faith is not a defense to a suit to foreclose or

mortgage. In the case of sureties however the law holds that an insane person is not bound by his contract of suretyship even though the creditor accepted him as surety without knowledge of his incapacity. With regard to promissory notes given by insane persons the general rule is that as such notes have no legal validity, although its consideration was necessaries furnished, yet though the note is void, the price of such necessaries furnished is a legal demand against the estate.

Contracts for Life Insurance.

A man may have a life insurance policy carrying certain options to be exercised at term e.g. 20 years. If the insured becomes insane after the insurance of the policy but before the expiration of the term at which option may be exercised and he has been prevailed upon to exercise a certain option provided for in the policy, said exercise of option is invalid though it grows out of the original contract made while he was yet sane.

The concealment of insanity at the time of application and examination or existing prior to it, constitutes a fraud hence such a policy will be declared void. Is an insurance contract vitiated by the suicide of the insured on the ground that suicide denotes insanity? Some insurance companies make special provision to declare the policy invalid if the insured meets death by his own hand "sane or insane".

In the absence of a provision invalidating the policy for "suicide, sane or insane" the courts have held in many instances that the suicide of one who is insane does not invalidate even though the policy contains a provision against death by the hand of the insured. These decisions rest upon the theory that insanity is a disease and that the taking of his life by the insured is caused by such disease. Torts are offences dealt with under the civil

law and include any wrong or injury to the person, character or property of another. Libel, slander, trespass, and adultery are torts which are not excusable on the plea of insanity. When insanity is proved in defense the damages however are quite nominal. In this case the law looks to the damage done to the injured person and not to the damaged state of mind of the injurer! It is however a libel to call a man insane when he is not !.

Marriage contract—In spite of numerous proposals before Parliament, even at this moment, to allow for divorce when insanity supervenes, the English Law still holds that insanity after marriage is no ground for divorce. In New Zealand however a divorce may be obtained on the ground that the respondent is an inmate of a mental hospital for at least ten years and is unlikely to recover. In Germany, insanity, of three years duration is absolute ground for divorce. In Norway, Sweden and Portugal, insanity that in all probability is incurable is sufficient grounds. In the United States, some of the States include insanity as a ground for divorce. Under the Mohamedan law the parties to the marriage must be able to understand the nature of the contact i.e., they must be major and sane. Proposal and consent are essential to a contract of marriage. If either is insane or defective the marriage is invalid. The Kazi has the power of granting a divorce on the ground of insanity. In however insanity supervenes after betrothal the contract may be broken and it is usually done by the other party, and that readily.

Insanes as Witnesses—An insane person, but not an idiot can be produced as a witness in a case. The judge decides on the competancy of the witness from his appearance, conduct and speech and the examination of witnesses acquainted with him. A

person may have many delusions and yet be able to narrate truly facts observed by him. An affidavit by an insane person may be filed if after due enquiry his mental state is found such that reliance can be placed on his evidence. Even an imbecile of a higher grade and a mentally defective person may be produced as a witness if the judge thinks he is competent to bear testimony.

(5) Criminal Responsibility.

Medical men are often called upon to give evidence as to the mental condition of an individual charged with crime at the time of its commission. That a man's life or death depends often upon this medical evidence, is sufficient emphasis for the close study of this important aspect of forensic psychiatry. True, the law deals leniently with a man who commits a crime when he is non compos mentis, but this state has to be proved fully and often it may not be easy. The difficulties that arise are due to the fact that the concepts crime and responsibility are not the same in the minds of the law and medical science.

Although legal text books define crime as "an act or commission forbidden by law under pain of punishment", one cannot give an accurate definition of crime. Crime does not mean the same thing in all countries, or at all times. The crime of yesterday may become the virtue of tomorrow. It changes with changing morality and with social necessities having no relation to morality. The idea of what is wrong in itself is not a fixed conception, it differs in time and place. The wrong of the West may be the right of the East, and so with past, present, and future.

The man who robs a bank is surely as much a criminal as the financier who corners the wheat market and starves thousands of the poor by inflating the price of bread. One is punished and the other is a pillar of society !

Responsibility—This word has roused a tremendous amount of controversy since it involves such concepts as volition, freedom of will, intent, motive, impulse, knowledge of right and wrong etc. and this controversy has been heightened not only by differences of opinion among psychologists but between them and jurists. From time immemorial the real question has always been whether the person accused of crime was capable of criminal intent. If a person is mentally unable to form such intent, he cannot be regarded as guilty under the law. The famous English jurist Sir Fitzjames Stephen maintained that "a person should not be punished for any act when he is deprived by disease of the power of controlling his conduct unless, the absence of control has been caused by his own default".

Excuses from conviction for crime have been summarised by Strand as follows:—

1. Absence of intent, because of:
   (a) ignorance of fact
   (b) legal incapacity by reason of infancy, insanity or drunkenness.
   (c) insufficient degree of intention.
2. Absence of volition because of:
   (a) natural compulsion (due to accident or chance, impossibility of compliance with the law) or automatism.
   (b) compulsion by human agency.
3. Coercion, actual or presumptive.
4. Occasional excuse (self-defence, provocation sudden or in combat).

Another aspect of criminality which is not viewed favourably by the law is the plea of irresistable impulse. There are

unfortunate persons in existence who though they know what they are about and also know that they are doing wrong are nevertheless impelled by diseased and irresistable impulse to commit a criminal act. This is common in the case of persons suffering from obsessional neuroses, chronic hallucinatory psychoses or even normal persons the subjects of sudden and intense jealousy. The law looks on this plea of compulsion as a large gap in the McNaughten rulings through which every criminal could escape under the clock of supposed insanity, and asks the pertinent question in reply to this plea from the medical side, "Would a man with an irresistable impulse commit a crime if a policeman were standing close by?

The present legal rule on this subject is contained in the replies of the judges of England to the questions by the House of Lords on the famous McNaughten case, the gist of which is as follows:—"That in order to establish a defense on the ground of insanity it must be clearly proved that at the time of committing the act the accused was labouring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing or if he did not know it; that he did not know he was doing what was wrong". Many objections have been taken to this ruling and difficulties constantly arose with administration of the law in criminal cases. The Royal Medico-Psychological association of Great Britain in January 1923 appointed a Committee of leading psychologists and penologists, to investigate the question of criminal responsibility and the unanimous conclusions of this committee are (1) The criteria of responsibility expressed in the rules in the McNaughten case should be abrogated and the responsibility should be left as a question of fact to be determind by the jury (2) In every trial in which the prisoner's mental condition is at issue the judge should direct

the jury to answer the questions (a) Did the prisoner commit the act alleged.

(b) If he did, was he at the time insane.

(c) If he was insane has it been proved that his crime was unrelated to his mental disorder.

(3) When a prisoner is found unfit to plead, the trial, on the facts should be allowed to proceed.

(4) The verdict "guilty but insane" should rank as a conviction for purposes of appeal.

(5) A panel of experts should be appointed, any of whom can be called to give evidence when insanity is raised as a defense.

The cause of the different attitudes of the law and medical science towards responsibility is that the former deals with crime in terms of act and intent and still holds to the old legal tests of irresponsibility, whereas medical science interprets crime as a "disease" and is concerned mainly with the personality of the individual, and the study of the psychological mechanisms and processes that are responsible for the act of the criminal with a view to treatment not punishment.

We now turn to the causes of crime. These may be divided into (a) general and (b) individual.

In 1876 Lombroso put forward the startling thesis that the criminal is born to crime, that he comes into the world destined to commit anti-social acts, because he is an atavistic phenomenon, a physical and mental degenerate. He taught that crime was associated with a particular type of individual whose physical characteristics were the hall mark of the criminal. The Lombrosian ideas received the death blow through the investigations

of Dr. Goring in England, Prof. Ferri in Italy and Dr. Healy in America. The modern view therefore is that physical characteristics have nothing to do with crime, a judge may look like a hardened "Jail bird" and a Bishop may be potential criminal, but that criminals are what they are because of a complex of causative factors such as heredity, development, social, emotional as well as intellective which play their role in varying combinations to mould their propensities, into a vicious or antisocial form.

(a) **General Causes**—Crime is more common in men than in women, among adults than young persons, and in certain months of the year.

(1) Alcoholism and crime are closely associated especially in Western countries, and this is not to be wondered at, for in all intoxications the powers of inhabition are removed and instincts and passions easily roused. In India, however the incidence of alcohol and crime is estimated at 3.5% but ganja addiction accounts for a larger number. Alcoholism be it remembered is only a symptom of some underlying mental instability. Drunkenness is no excuse for crime, but a history of delirium tremens or alcoholic insanity secures acquittal.

2. Bad environment.
3. Poverty.
4. Bad Heredity.
5. Lack of education.

The above four classes may be considered together. In themselves they are not sufficient to produce crime. The wonder of it is that the population of a poor slum area do not produce more delinquents. There must therefore be some additional cause. Crime is assignable to no single universal source nor yet to two or three, but springs from a group of alternative and converging

influences. Still in any given case some single circumstance stands out as the most influential.

(b) Individual cases; The question is why does a particular individual commit crime and the answer can only be found by an investigation of the individual's mental condition. The mental state of criminals is abnormal, hence a large proportion of crime is assignable to

(a) mental disorder or insanity.
(b) Mental deficiency or amentia.

The diseases in which crime is most common are, in order of frequency;

1. Dementia praecox
2. Manic depressive psychoses
3. Epilepsy
4. G. P. I.
5. Senile aud Presenile Psychoses.
6. Encephalitis lethargica.

In Amentia, the gross idiot is practically immune to crime but feeble mindedness in both adults and young persons is the cause of a very high percentage of crime. Juvenile dilinquency is due to a wide variety and a plurality of converging factors. Heredity operates indirectly through such congenital conditions as dullness, deficiency, unstable temperament or excessive development of some single primitive instinct. Of environmental factors, defective home discipline seems the most important while a vicious home atmosphere, undesirable influences outside the home, and the pressure of poverty exert a smaller yet appreciable effect.

In a criminal case where insanity is alleged it must be proved that the crime was the direct result of insanity, if not the defence

will not succeed. Not only in cases of alleged insanity is a thorough mental examination and report necessary but every person charged with a crime should be similarly examined.

In the state of Massachussetts, Dr. Vernon Briggs of Boston in 1921, introduced a Bill which provides for the examination of the mental state of every person indicted for a capital offence or for any other offence committed more than once. This humanitarian procedure has been copied in most countries and the International Prison Congress held in London in 1925 agreed to the following proposal " It is necessary that an accused as well as a convicted person should be physically and mentally examined by specially qualified medical practitioners and that the necessary services should be installed for this purpose in the Institution. Such a system would help to determine the biological and sociological causes of criminality and to suggest the suitable treatment for the individual offender ". This does not mean that the ends of justice are to be defeated by molly-coddling every criminal, but that a man who is not responsible for his actions by reason of a disordered mind, should be mercifully protected from the full weight of the criminal laws.

When a man is arraigned or during a trial, the question of insanity is raised, the jury is asked to decide whether the prisoner is able to plead or not, or whether he is sane or not. If he remains mute of malice or ex visitatione Dei, the plea 'not guilty' is entered and the trial proceeds. When he is found to be insane an order is made for his detention in a mental hospital as the verdict "Guilty but insane" is usually returned. When there is any real doubt as regards the question of insanity the benefit of the doubt should be given to the accused. It does not follow that because a man is insane he cannot plead. In cases of Para-

noia and Melancholia the prisoners intellect may remain sufficiently clear to fulfil the conditions requisite for the arraignment and he may conduct his own defence with skill and alacrity.

When a criminal patient later recovers from his insanity he may be put up on trial even years later, unless in the meantime he had, while in hospital been transferred from the category "criminal" to "non-criminal" but in practice this is rare and the result is usually an acquittal. The phrase "guilty but insane" is misleading as it suggests conviction. The prisoner is not found guilty of a crime, the verdict merely records that he is "guilty of the act charged against him but was insane at the time so as not to be responsible according to law". There is no appeal against this verdict and the sentence, an indeterminate one, is detention in a mental hospital "until His Majesty's pleasure shall be known". The psychiatrist's or the medical witness' concern is to give his evidence on the facts of the case faithfully. When in the witness box the physician or medical expert should give his answers clearly, briefly, and simply so as to be understood by Bench, Bar and Jury. To indulge in technical terms is to count endless cross-examination. Never argue or lose your temper. If asked whether the prisoner was responsible for his actions your only answer is that responsibility is a legal question so that the judge or jury should decide. When a medical expert is examined the testimony is based largely on hypothetical questions. In considering a hypothetical question for purposes of answering the same, the witness must confine himself strictly to the statements included in the hypothesis and consider no other facts or circumstances than those stated. As a rule, medical books are excluded as testimony, because medicine is an inductive science and experiment and discovery are constantly changing theories. Authors do not write their books under oath and cannot be cross

examined as to the grounds for their opinion, but if a standard medical text book is quoted by the deffence with a view to testing your knowledge or upsetting your evidence you must either state your acquaintance with the book or not and formulate your opinion strictly according to the facts of the case or appeal to the Bench that a text book is not admissible evidence.

A prisoner who becomes insane while serving his sentence (insane criminal) may be transferred to a mental hospital. Should he then recover in the hospital, the practice at present is to allow such person to remain in the hospital till his term is served and not return to prison.

Owing to the want of a mental deficiency act for India defectives are treated as insanes. The legal 'irresponsibility' of mental defectives has not been fully determined and it is highly desirable that it should be. A very large proportion of persistent and juvenile offenders are mentally defective. In England about 30% of the criminal population are found to be defectives. The increase in the juvenile population of Indian prisons for political offences is due not so much to mental defect as to the emotional instability of particular classes.

AMNESIA AND CRIME.

Next to being mute of malice, the commonest symptom an accused may plead is loss of memory for events prior to, during or after the act, but mostly, denies all knowledge of the act. This amnesia may be feigned or genuine. A person may be mentally abnormal and still feign loss of memory and some difficulty may be experienced in differentiating between the true and feigned forms. Genuine pathological amnesia may occur in the following conditions :—

Alcoholism
Epilepsy
Dissociation in (a) Somnabulism (b) Fugue
Head injury
Depressive states.

Amnesia is rare in schizophrenia and paranoid states. It should be remembered that though post-epileptic automatism is genuine and accepted by the courts as defence, which is often successful, an epileptic who commits a crime for which he is legally responsible may trade on his history and feign amnesia to escape lightly.

In dealing with cases of amnesia associated with crime the following points should be remembered.

(a) A sudden return of memory of the events is strongly in favour of malingering.

(b) Repression may account for genuine amnesia, even if statements are made soon after the crime showing knowledge of the act.

(c) When points in favour of the accused are remembered and everything else forgotten he is probably malingering.

(d) The character of the amnesic period is important. In genuine cases the beginning and the end of the episode are generally hazy.

(e) There is often no motive for the crime, premeditation is not a feature and the culprit makes no attempt to escape or cover up his tracks.

(f) The first account given by the accused is of utmost importance and should be noted in detail. The story must be checked by the facts known and especially the independant evidence of witnesses.

(g) Frequently a history of chronic alcoholism, neuropathic heredity or previous attacks of insanity is elicited and is in favour of genuine amnesia.

Treatment of the criminal.

The futility and inadequacy of customary methods of dealing with persons charged with crime is becoming apparent the world over. Just as wars cannot end wars, punishment cannot deter and reform at the same time. In many cases of crime the fundamental cause is some mental instability, hence treatment, not punishment is the proper and sane method to adopt.

It seems obvious therefore that every court should be aided by a psychiatrist in any case in which the offence committed might be due to a disordered personality. The principle of the Massachusetts Law should be adopted in criminal courts in India by providing for the mental examination of accused and should be a condition precedent to admission to bail. Psychiatric clinics may well form parts of police courts and prisons where psychoanalytic investigations should be undertaken.

As to detention there is no doubt that an indeterminate sentence has its values for the more an offender realises his freedom rests with his ability to prove that he can safely take his place in society, the better will he co-operate for his reformation. If the indeterminate sentence of certification has not been abused and is beneficial in the case of insanes, so may it be with delinquents. The usual verdict " guilty but insane " should be changed to " not guilty by reason of insanity ". In a mental hospital criminal insanes should uot be segregated as such. Often such patients are the best behaved in the hospital. A system of parole should allow for the temporary release of criminals to the care of friends, relatives or after care associations or to remand Homes, Capital punishment should be abolished.

(6) Juvenile Courts.

The Juvenile court is a comparatively recent innovation both in this and other countries and provides for the trial and treatment of boys and girls under 16 who are delinquents or have committed serious offences. The fundamental function of a juvenile court is to put each child who comes before it on a normal relation to society as promptly and as permanently as possible. Punishment though not dispensed with is subsidiary and subordinate to the purpose of correction of conditions, care and protection of the child and prevention of recurrence through the constructive work of the court.

In India there are juvenile courts in the Presidency Towns and a Children's Act is in operation in Bengal, Madras and Bombay. All offences except homicide committed by persons under 17 are dealt by this court. No child under 8 should be charged with any offence. A juvenile court should be situated in a building shorn of all pretence to a Government Institution and the interior so fitted to resemble more an ordinary residence than a court.

Magistrates who sit in juvenile courts should be specially qualified for the work and specially selected for it. Proceedings in a juvenile court should be as private and informal as possible care being taken to limit the number of persons present and even the police should be excluded if possible and in any case never allowed to enter in uniform. The charge, examination or enquiry should be in the simplest language possible. At any stage questions of the mental or physical fitness of the child may arise. Attached to the court should be a staff of officials much like that of a child guidance clinic, the psychiatrist, medical officer, probation officer and social workers. These will contribute an authoritative opinion on questions which fall under four heads, so that the

punishment is to be deprecated but may be necessary in exceptional cases. Imprisonment should be abolished for young prisoners below 17. The alternatives are placing an offender :—

(a) Under the guardianship of persons who are not parents or relations.

(b) On probation for a term in a remand Home or special school under the supervision of a probation officer.

(c) In a Borstal institution or Reformatory.

(d) In an Industrial school.

(e) Attendance at a clinic for psycho-analysis. After probation or term in a reformatory there should be no restriction of movement or Surveillance by the police, of the offender. It may be remembered that if punishment does not alter or reform the adult it is less likely to do so with Juveniles especially if they are also defective.

Probation is a system by which a delinquent undergoes a term of supervision, care and training in a school, reformatory or in his own home under the vigilance of a probation officer. From a social point of view it may be said to be a process of educational guidance through friendly supervision. Not only is it a form of surveillance but also deals with all the factors of the probationers life. The most important feature of probation is the personal attention of the probation officer to the probationer. This attention is given by visits to the home, by acting as arbiter between the child and unreasonable parents, by friendly talks with the child at the time of reporting, by conferences with the child and the teacher at school for the adjustment of school difficulties, by accompanying the child to hospital, by assisting in straightening out disputes with friends or relatives, by helping him to obtain work, introducing him to clubs and parties, and in many other

ways. The ideal probation officer, who in addition to being the sole executive officer and to a great extent in delinquent cases the eyes, ears and brains of the juvenile court as well, is not easy to find. Probation work demands the best and highest qualities in a man or woman, a working acquaintance with child psychology, a wealth of enthusiasm and patience, the consecrated devotion of a clergyman, the amiability of an efficient teacher and the discernment of the skilful physician.

CHAPTER XVI

NORMAL PSYCHOLOGY.

In the foregoing chapters we have seen how mental disorders arise from defect or disease of the mind, and in order to further understand these pathological states a consideration of the normal function of the mind is necessary. In the course of evolution the human brain attained a higher sphere of perfection than that of the lower animals, but that attribute we call the mind is common to all living creatures, and as we ascend the scale till we reach the genus, homo sapiens, we find that the development of the mind is only a matter of degree, and is highest in man. Upon the well-being and normal functioning of the cerebral neurones are mental processes, whatever their nature and origin may be, entirely dependent. What the essence of mind is, is pure speculation, but mental phenomena are said to be the direct result of physical processes which occur in the neurones. This is known as epiphenomenalism. The opposite view to this is psychic monism, in which consciousness is regarded as the only reality and that matter has no existence outside consciousness. Both matter and mind can be considered as manifestations of force or energy in nature. The philosophy of Bergson, with it's " elan vital " corresponds to the animistic theory that some non material " spiritualistic " agency in living things exerts an influence over their actions. Whatever we conceive the mind to be there can be no doubt that without nerve cells there can be no mind. When we speak of mind we mean that faculty by which we become aware of our surroundings in space and time. Such a view however does not cover the whole field, for the mind belongs to the organism as a whole, as a unity. The mind is that function of the organism by which it lives as an individual entity. The organisation of the body as a

whole depends upon a working in harmony of it's various functions, a coordination of the purpose of each unit system into a single team under the control of the central nervous system. Each activity of an organism is purposive and adapted towards some definite end, advantageous to itself or it's species, and is a response to a stimulus. Such response is termed behaviour which is simply an adaptation of the organism to it's environment.

Consciousness or awareness however is not necessary for the behaviour to be purposive. It does not contain all our motives. Man is more than the sum of his own experiences and possesses the experience, force and motives of bygone generations.

His behaviour is often motivated by his inherited primitive instincts and childish wishes, hence purpose or Behaviour is dynamic in nature. This is the essence of Freud's psychology. According to him the mind consists not merely of the conscious processes of knowing, thinking, and feeling, but a deeper unconscious-which includes the basic energy of life, the primitive instincts, wishes and emotions which have been innate or existed prior to the development of a differentiated awareness. In the lower animals and simpler organisms, what we understand as consciousness is either present in a very minor degree, or non-existent. Their behaviour is more or less instinctual or governed by conditioned reflexes. The great increase in the size of the human cerebral cortex and the great increase in the number of the neurones in the human cortex in comparison with animals, depends largely on the relative size of one part of the cortex only, viz the supra-granular layer.

Berry divides the cerebral cortex into three layers, the infra-granular, granular, and supra-granular.

(1) The infra-granular is the oldest layer of the cortex, the first to appear and most quickly to attain maturity. It forms a

lower level basis for the carrying on of cerebral function. It subserves the animal instincts of sex and self preservation. Judgement, common sense, reason as evidence in behaviour, are dependent on the control of the activities of this layer by the supra-granular layer. It is equally well developed in the feeble minded as in the normal person.

(2) Granular layer is the original layer of termination of afferent fibres aud hence it is probably sensory in function.

(3) Supra-granular layer—It is the last layer of the cortex to to be evolved, the last to commence to develop and attain maturity but the first to undergo retrogression. It subserves the higher thought processes and the layer through which education largely works. It varies in depth in normal brains and under-developed to different degrees according to the mental capacity of the individual.

It is here that the higher psychical functions take place that enable man to reach an enormously higher intellectual, ethical, aesthetic, social and moral plane in comparison with the rest of creation. Increasing complexity of structure carries with it greater variety in the patterns of response, so that in man we may distinguish four distinct levels of specific response to environmental stimuli.

(1) Primitive chemical level.

(2) Reflex action.

(3) Instinctive action, in which consciousness begins to play a part.

The three attributes of cognition, affection, and conation are involved in this response.

(4) Volitional action. This is characterised by choice and purposive modification of responses, often in apparent opposition

to the lower instinctual levels. At this level only can mind be said to exist in a fully developed form. With the development of volition we suppose that man is endowed with a "free will" but we shall see later that Freud explodes this universal belief. The three main attributes of the mind are cognition, affection and conation. One or more of these may dominate any mental process but the mind works as a whole and by their unity constitute awareness or consciousness. Consciousness is lost when :

1. The blood supply is diminished below a certain level.

2. Poisoned by the toxins of any disease or by drugs.

3. The neurones suffer physical shock as concussion or pressure.

Cognition is the awareness by the subject of an object and includes sensation, perception, ideation, imagination and thought.

Affection is the feeling tone by which the subject is affected by the object and it includes feeling, emotion, passion, mood, sentiment, and temperament.

Conation is the urge or striving by which the subject acts upon or towards the subject. It includes volition, impulse, desire, wish, libido, need, interest, and attention.

Consciousness is the result of the reception in the cortex cerebri of a continuous flow of stimuli from the various end-organs of sensation. If all sensory stimuli could be inhibited consciousness would cease. With each stimulus therefore the subject is aware of itself in it's environment, is affected by it, and urged to a particular behaviour the situation demands. Mental functioning must be selective in it's reaction to sensory stimuli which pour in. There seems to pass through consciousness which may be compared to a stream, a sort of wave, on the crest of which is the

most active part-attention, while behind it is what is passing out of our attention and in front, what is gradually coming into our attention.

Sensation.

Sensation is a mental process of the most elementary type resulting from the stimulation of a sense organ by which the organism is aware of change produced in it. Every sensation has four attributes.

(1) Quality. Every sensory end organ can produce only it's particular specific sensation.

(2) Intensity—A sensation varies according to the strength of the stimulus and the degree of attention paid to it. The Weber-Fechner law formulates that a sensation increases as the logarithm of the stimulus, the logarithmic base varying for the different qualities of sensation.

(3) Duration or protensity; i.e. it's relation to time or the interval between the stimulus and cessation of the sensation.

(4) Extensity is the amount of space over which a sensation is spread. Sensations are divided into (a) Special, visual, auditory, olfactory, gustatory, tactile. (b) Kinaesthetic, of position and movement, derived from muscles, tendons and joints. (c) Coenaesthetic or organic. The normal functioning of the various organs do not produce sensations of sufficient intensity to enter consciousness, hence we are unaware of their presence or functions. They reach consciousness only when some adjustment is necessary, as bladder or bowel sensations, hunger and thirst. When an organ thrusts it's presence into consciousness it is either diseased or disordered.

Disorders of sensation.

(1) Anaesthesia is loss or dimunution of sensation and may be general and complete or localised and partial, or it may effect special sense organs. It may be due to (a) organic, (b) functional causes. In psychiatric practice anaesthesia is met with mainly in hysteria and in the insane in dementia praecox, acute confusional states, melancholia, and demented patients and in the later stages of general paralysis.

(2) Hyperaesthesia—All the senses are hyperactive in acute mania and in the first stages of alcoholism and drug addiction. On account of the hypersensitiveness of the skin, acute maniacs tend to discard all clothing. Intolerance of noise and lights is a common complaint of patients who are neurasthenic and melancholic.

(3) Paraesthesias—are perversions of sensation and include illusions and hallucinations. A hallucination is a sensory experience without real objective stimuli, whereas an illusion is a false perception of an external reality. Hallucinations may effect one or more of the senses of a patient, and occur in about 50 per cent of the insane. The commonest are of the auditory variety. The "voices" may be accusatory, abusive or threatening; "wireless messages", or the "voice of God" are commonly heard. The patient's entire behaviour and attention may be dominated by them. In some cases they may impel the sufferer to commit suicide.

Visual hallucinations are more common as the aurae of epilepsy. Flashes of light, colours, faces, and even animals may be seen. In the "horrors" of delirium tremens the patient is haunted by weird or terrifying reptiles or animals.

Olfactory and gustatory hallucinations, in which the patient smells or tastes poison in his food are commonly found in para-

noiacs and general paralytics. Cutaneous hallucinations in the form of "electric shocks", formication, and tingling are usually complained of by alcoholic patients.

Visceral hallucinations are subjective sensations felt in the internal organs and even the genitals. They may occur as an aura in epilepsy, and the psychoneurotic may complain of tumours in his organs, or worms and insects crawling inside the skull. The pseudocyesis of the hysteric comes within this category. Hallucinations occur also in dreams and in hypnosis. To the patient the hallucinatory experience is real, and to tell him he is imagining will be of no avail, for he will believe his own senses in preference. Hence the resulting behaviour is governed by the hallucinations which the insane adopts into his personality. If however a patient is able to realise that the hallucinations are not real, and his judgement tells him that they are foreign to his senses, the condition is hopeful. The more acute the psychosis, the stronger is the influence of the hallucinations. If they persist even when other symptoms of disorder have abated, the psychosis is apt to become chronic. The psychological explanation of hallucinations is that they are of the nature of wish fulfilments or of anticipations. There are many theories as to the physical basis of hallucinations but none can be taken as satisfactorily conclusive, yet it must not be forgotten that a pathological disturbance of a sense organ or tract may not be appreciable objectively but may form the basis of a hallucination.

Perception.

Perception is the impression in consciousness of an external object. It is derived from sensations and their relation to objects, as well as memories of previous similar sensory experiences, and to which a certain feeling tone is attached. Whereas the older

view was that the infant's or young animal's experience consisted originally of simple sensations from within or without of smell, taste, and hearing and later of thirst, and that these were amplified later by associations with similar experiences or with memory traces of previous ones in perceptions, it is now believed that what the infant first obtains in his consciousness is a general impression, blurred at first but gradually discriminated into it's separate component parts as time proceeds. An entire system of psychology has been built up on this total perceptive ability and has been called the "Psychology of Wholes" or "Gestalt" Psychology. In reading a familiar phrase like "yours very sincerely" we do not react to the isolated letters but to the phrase as a whole. The strength or weakness of a perception depends on the amount of attention directed to the object, hence attention and perception are closely connected, but perception may also be an unconscious process.

For instance, the ticking of a clock in a room may pass unnoticed, but immediately it stops one is aware that something is amiss. Apperception is the faculty which enables one to learn from experience and has also been described as attentive awareness (James).

Disorders of Perception.

(a) Diminution of perception or imperception (Agnosia) occurs when the various special sense stimuli are not strong enough or in spite of them. Thus in acute and chronic alcoholic insanity, in acute confusion, and in cerebral arteriosclerosis, if a patient is shown, say a watch, he sees it but does not perceive what it is. Alexia or work-blindness, and Agraphia or the inability to express ideas in writing are forms of imperception and are present in lesions in the visual perception areas—

(b) Hyperception occurs in acute mental disorders and in neurasthenia.

(c) Perversion of perception. Illusions and hallucinations fall within this category. An illusion is a false perception aroused by an external object. The common optical illusions are of this nature. Illusions also tend to occur when the impression or stimulus is vague or confused.

Ideation.

Ideation is the process of forming a mental image or picture and is concerned with the higher mental processes of thought and intellect, and involves the operation of memorising. When one sees an object one perceives it, but when one thinks of it an idea is formed. An idea is a perception in thought, the memory of past perceptions, memory images or representations. Just as sensation is necessary for a perceptions, so an image and the meaning it conveys is the basis of an idea. With the formation of an idea there is an accompanying feeling tone of pleasure or the reverse, which is called emotion. Like sensations, ideas have quality, intensity, extensity and protensity. Ideas or memory images may be controlled by the will, they are less vivid than real percepts and the feeling of reality is less than that of a percept. A concept however is the abstraction and recombination of the qualities of a number of ideas or percepts. Such abstractions as health, happiness, truth, virtue are concepts, but a conception is not loftier form of thanking. To think of an object is to conceive it, to know, recognise, to be aware of any object is to conceive it, even when our knowing is a perceptual knowing. Perceiving is one way of conceiving. "The difference" according to Professor Stout, "is often represented as identical with that between the universal and the particular."

"In perception the universal an dparticular are indistinguishably blended, the universal element lies entirely in the bare fact that the particular is recognised. Now the essential character of conception is that in it the universal is thought of as such in contradistinction to the particular, implicit in the percept, it is explicit in the concept". Ideas are brought out or expressed through the medium of language. By means of sounds or signs all living creatures convey their ideas one to another. Words are the highest development of sounds by which a human being symbolises ideas that are communicated and understood by each particular group or race of individuals. Man then converted the sounds into graphic signs and symbols to preserve the accumulated knowledge of the past and to communicate his ideas to others and succeeding generations. From the primeval pictorial representations of ideas there gradually evolved the signs or alphabets symbolising sounds, and from this we have the written language. Ideas like sensations do not occur singly, but bring with them a train of others, in conformity with the laws of association which is as follows. " Ideas, sensations or emotions occuring together or in close succession tend to adhere together in such a way that when any one is afterwards present in the mind any of the others are apt to be produced." Simultaneous or successive experiences are connected with each other and revival of the one of these recalls the others. Associations of ideas occur because of singularity or contrasts or from contiguity in spatial or temporal experience. The prevailing emotional state at the time of any experience is deeply engrained and facilitates recall of the experience.

The associative process depends on the recency and frequency of association, the vividness of the first experience and the degree of attention or emotion aroused thereby. Logical thinking

is at first a repetition, an ekphoria of associative connections that were once experienced or of similar or analagous connections. Casual thinking is only an analogy of the regular sequance of two ordinary events, or of the general sequance of two universal events.

Disorders of ideation.

(1) Absence or poverty of ideas is seen mostly in profound degrees of amentia and dementia. It also occurs in states of acute confusion, stupor, melancholia and in dementia praecox.

(2) Acceleration or "Flight of ideas" is most prominent in states of excitement, as acute manias, alcoholism, and katatonic excitement. The result is that the conversation is rambling and incoherent.

(3) Retardation of ideas; A wandering or difficulty in association is usual in melancholia, drug addictions, and also in general paralysis and neurasthenia.

(4) Fixation of ideas occurs in obsessional neuroses and are of an imperative nature dominating consciousness. In dementia praecox too, examples of this fixation is seen in verbigeration, echolalia and echopraxia. In acute confusion as well as in secondary dementia, ideational inertia is a frequent symptom. If the patient is shewn an article he names it correctly but every other article next shewn to him he names them the same as the first.

A complex is a system of emotionally toned ideas clustered together because of a particular bond of emotion. A complex may also be of instinctual origin and hence it's mechanism and motive may be quite unconscious. Thus a man who turns all his thoughts and energies to making money has a money complex of which he is conscious; whereas a man who is attracted by

elderly spinsters may be said to have a mother complex, which is the result of an unconscious "mother-fixation".

MEMORY

The fact on which memory is based may be stated thus. When neurones are stimulated and perform their function a condition is produced in them which renders them more easily stimulated again, an engram or residuum of the impules is retained in the neurone. To a certain extent the effect is permanent. The passage of an impulse along a neurone leaves an engram, a memory, this memory being the facilitation for the passage of a future impulse. Even the trauma of birth is registered to some extent and may be regarded as the earliest engrams to be registered. Throughout life every stimulus is registered and canalised, but however capable a brain may be, its capacity is limited to its experiences, to the sensory impulses it has received. A person can only recall in thought what he has experienced, he can only make use of past memories in thinking. He cannot create a new sensation by stimulating the neurones from within, that is, in thought only. He can however combine past perceptions, old memories, old ideas in new forms. This process is called imagining, but the principle that the neurones can only in the first place be stimulated from the sensory organs is of great importance. This does not cover the whole field however, for there is such a thing as the "archaic inheritance of thought" which can neither be classed as a true memory or an instinct.

Memory then is the retention of previous impressions on the mind so that they can be recalled again into consciousness. This new mental percept is termed a "revived image" which is similar to the original but not so vivid or intense. The revival of a memory may take place.

(1) by a repetition of a sensation or a similar one:

(2) by an association of the previous sensation:

(3) by an act of will, and this usually by associations. Registration and retention depend not only on the vividness of the impression received but also upon its emotional value, the recency of the experience, and its repitition. What interests us most we remember most.

Disorder of memory.

(a) Amnesia or loss of memory, may be, (1) Partial, as in the inability to remember names in senility and in aphasic states. (2) Progressive, as in general paralysis and drug addictions and secondary dementias. (3) Temporary as in epilepsy and commotio cerebri (4) periodic as in hysteric fugues and automatisms and in hypnoid states. Amnesia may be either an inability to retain new impressions (anterograde) or to recall previous ones (retrograde). In melancholia and amentia especially, the amnesia is chiefly anterograde. Not only may one forget present events or of the past, but even those of the future that have not occurred. Thus an event or an appointment at a future date may be carefully noted and yet forgotten on the due date.

(b) Hypermnesia or hyperfunction of memory is seen most in states of excitement as in acute mania and in the excitant stage of alcoholism or drug addiction. Not only will a patient remember events which have occurred even as long ago as childhood, but every little event that occurs during the excited stage may be remembered and accurately related months later when the patient recovers. Persons rescued from drowning often relate how events of their whole past life is visualised or recalled in rapid succession.

(c) Paramnesia or perversion of memory is a constant symptom in Korsakow's syndrome. In this disease events are confabulated that never occurred at all. If such a patient is asked what he had done the previous day he will give a long account of a trip into the country, the sights he saw and whom he met, though he never left his bed.

The memory of this will remain although amnesia for other events may exist. Failure of memory follows the law of dissolution, the recently acquired memories are the first to fade while the more older, organised ones are the last to go. Hence it is in senility that dotage and " anecdotage " go hand in hand.

Affection.

Every stimulus an organism receives is not only perceived as a sensation but is also felt, and the subjective feeling is one of either pleasure or pain. The mode of behaviour is regulated by the feeling tone, for the whole of life is towards the avoidance of pain and the acquiring of pleasure. An emotion which is the feeling tone attached to the higher mental activities of ideation, memory and intellect may be looked upon as the psychical result of a reflex action. Emotions are closely allied to the instincts. The primary seat of the emotions is probably in the thalamus. Through Monakow's rubrospinal tract they are expressed in muscular movement. The Thalamus however has direct connections with the cortex and all the affective impulses pass through the thalamus which is a kind of " sorting station " before the impulses pass through to the pyramidal and extrapyramidal tracts. Pleasurable feelings are accompanied by dilatation of the arteries, deeper respirations and increase in pulse rate and muscular action, while the physical correlative of pain is, contraction of arterioles, raised blood pressure, shallow respiration, slower-pulse and decrease of

muscular power. Emotions may arise from visceral sensation too. The endocrine system has also some influence in the production of emotions. One sees the influence of the gonads in disturbances of and in the intensities of emotions, of the thyroid in intensifying the activities of the individual and increasing the sense of fear and nervousness. It has been said that in the great war many men for the first time " discovered " their adrenals "and many as the result have had their bodily activities changed ever since." The biological importance of emotion lies in the fact that the attention of the organism becomes focussed on some point so that the ensuing reaction is coordinated to some purpose. Emotion causes several disturbances in the mechanical control of the voluntary and involuntary nervous system. The rate of the heart beat, respiration, intestinal movements, secretory activities of all kinds are the result of emotional stimuli, but according to the James-Lange theory, emotions are directly dependent upon certain bodily changes which proceed the emotions. James' argument is as follows, " if we fancy some strong emotion and then try to abstract from our consciousness of it, all the feelings of it's characteristic bodily symptoms, we find we have nothing left behind .....purely disembodied human emotion is a nonentity ". Whether or not this theory is accepted in substance ; in spite of Sherrington's experiments on decerebrate and despinalised dogs, or Golla's psycho-galvanic reflex, we are forced through want of a better term to designate the physiological signs by which an emotion is manifested as expressions of that emotion.

Disorders of emotion.

Deficiency or diminution of emotion occurs chiefly in dementia praecox, melancholia, amentia and in stuporose states. Excess of emotion is characteristic of hysteria. It is curious to note that in hysterics the psychogalvanic reflex is diminished or

absent. Maniacal persons manifest an exaltation of emotion. Alcoholics, epileptics and general paretics have also an excessive emotional reaction.

Perversion of emotions are found among sadists and masochists and also psychoneurotic persons who have transferred the affect belonging to one idea to another. A passion is a strong emotion of short duration, while a mood is a mild emotional state that lasts for a period of time that is variable. A temperament is defined by Stoddart as "the mood which lasts the greater part of a man's life". McDougall defines it as "the sum of the effects on the mental life, of the metabolic or chemical changes that are constantly going on in all the tissues of the body of an individual". It is possible that every tissue of the body contributes to determine temperament in this chemical fashion, certain tissues being of vastly greater influence than others. The secretions of the endocrines is most important. Witness the activities of the thyroid gland. If the thyroid secretion becomes deficient in quantity the patient becomes sluggish, unduly calm, his mental processess are slowed and in extreme cases he is almost torpid If the defect occurs in early age the physical and mental developtment is retarded and the child may grow up a cretinous idiot When the thyroid secretion is excessive, the activities of the nervous system and other tissues also are accelerated, the patient becomes excitable, restless and agitated. The organs of the body too contribute to the development of temperament. Thus a perfectly working digestive system tends to a cheerful and contented tone of mind, while a sluggish or poor digestion makes one peevish and melancholic. According to Jung the degree of introversion of an individual is a strong factor in determining the course of mental development which in the case of introverts is determined by internal factors, and that of extraverts by the

influence of their environment. But racial and hereditary influence too determine a man's temperamental development and influences growth of both intellect and character. In addition to Galen's ancient description of the sanguine, phlegmatic, choleric and melancholic temperaments there are others which are partly described by such adjectives as buoyant, slow, quick, nervous, social, antisocial, cyclothymic, autistic, etc.

A sentiment is an emotional disposition permanently laid down in the mind in relation to some object. It differs from a complex in that the latter is an acquired conative setting which is in some degree morbid by reason of its lack of harmony with the rest of the character of an individual. A sentiment is "concrete" when it is centred upon a definite object, as a place or person. It is abstract when it refers to a quality as beauty, honour, justice. The three main classification of sentiments are (a) Moral. This includes a regard for such concepts as right and wrong, religious convictions and social conventions. Morality is simply the result of subjugation of self to the tenets of herd law. (b) Intellectual. This deals with the reasoning processes of belief, disbelief, judgement by rational deduction and intuition or suggestion. (c) Aesthetic—These are concerned with tastes for arts, literature, music, culture, and form.

A belief is an ideational deduction arrived at by a process of ratiocination when evidence is weighed and judgement passed. Reality is experienced through sensory impressions but some deductions cannot be tested by actual experience. Therefore belief is to accept something as true without logical proof and to consider something as probable. Superstition is a weaker form of belief tinged with a fear of punishment and seeks to avoid it by an act of propitiation of a symbolic kind. Superstition is deep

rooted in the human race and unconsciously motivates the behaviour of a great many. To be dominated by a superstition is to be dominated by the unconscious motives of fear and guilt. This is closely allied to the obsessional neuroses which when analysed is a defensive ritual, symbolic as well as propitiatory, and at the same time satisfying an infantile and unconscious wish. Belief becomes pathological only when it dominates the psyche far too much and when it resists correction in spite of experience and the laws of logic. It is then termed a delusion. Delusions are closely allied to hallucinations and generally accompany the latter; the difference between the two being that delusions are not false sensations but false belief—an erroneous judgement. Delusions may develop out of hallucinations and are found in most mental disorders, but are not necessarily a sign of them. Delusions may be sane or insane. A sane delusion may be the result of lack of education. For instance an uneducated person may believe that the sun goes round the Earth and to correct it he must be educated, but if an educated person had the same belief he would be noted as insane. When conduct is governed and disordered by delusion, certification becomes necessary. An insane delusion cannot be shaken by any amount of argument because there is no insight of the abnormality of ideation. Delusions may be of all kinds, grandoise, persecutory expansive, absurd, fantastic, and hypochondriacal. They are generally classified as (a) systematised and (b) fleeting. The former are fixed, do not change and are bound together by logical trains of thought. The patient adheres to them because he substantiates them by every possible argument. A fleeting delusion is one that is ever changing and not co-ordinated with other processes of consciousness. The presence of a delusion, even when conduct is fairly normal, is a serious sign of mental disorder. Delusions of reference are those where

every event, however trivial which happens in the patient's environment is misconstructed as referring to, or bound up with the patient's fate. For example, if the patient sees two persons walking together he may believe he is being discussed, spied upon, or a plot is being hatched against him. When called upon to examine or certify a patient care should be taken to note every statement of the patient, to detect the presence of delusions. Sometimes this may be an easy matter, but it must be remembered that if delusions are to be quoted as facts indicating insanity the physisian must satisfy himself that the instances he gives can safely bear the scrutiny of a court of law.

CONATION.

Conation naturally succeeds affection and is determined by it; all striving is prompted by the feeling of pleasure or pain. Since all living organisms have the power of independent reaction towards environment to which they must adjust themselves, their conduct or behaviour is purposive. The nature of human conduct may be reflex, instinctive, automatic or volitional. A reflex action is an immediate motor response to a stimulus. All reflexes are protective mechanisms and hence purposive. If we had no reflexes we would soon succumb to the numerous injuries and dangers that beset life. Consciousness, if present, plays no part in reflex activities.

Instincts are inherited complex reflex acts the performance of which is consciously purposive though independent of previous experience, and are invested with an emotional tone. Instincts are the motor expressions of the emotions.

Intelligence however is the capacity to improve upon natural tendency in the light of past experience. It is the result of learning by trial and error. Instincts differ from reflex activities

in that though they are innate, they are not necessarily present at birth but appear in the course of development. Habits also, though allied to instincts, are acquired through education, repetition, and the emotional interests of the subject. Many so called instincts are social habits. An individual's behaviour is moulded by the dynamic urge of his instincts, plus the repressions or barriers of education; using that term in it's widest sense. Hence, one's natural instincts and the conventions, restrictions, and taboos of society are continually in conflict. The instincts are always striving for expression and their fulfilment results in gratification, but if thwarted gives rise to mental unrest. The three primary instincts are:

(1) Preservation of self—(self)

(2) Preservation of the species (sex)

(3) Herd instinct (society).

McDougall holds that there are twelve simple instincts with their corresponding emotions, such as flight, pugnacity, self assertion or abasement, acquisition, reproduction etc. but each of these can be grouped in one of the three primary instincts. Instincts being primitive or 'animal' in nature are constantly restricted in man according to the degree of his civilization. The Ego and sex instincts are generally inhibited by the higher and stricter herd instinct and conduct has to be regulated according to herd law. When there is conflict with the rules of society, or between the Ego (conscience) and sex instincts there is engendered a state of unhappiness or unrest. One of three things may now happen. The urge (wish) may be gratified in defiance of all barriers or inhibitions, and the individual may be completely happy and satisfied, even if cut off from the rest of the herd. 2. The instinct, most usually sexual, may be modified or sublimated

into more useful channels of activity i.e., it is repressed or inhibited. Complacence or relief results so long as the counter forces of repression are strong enough to divert the emotional tone of the forbidden instinct. 3. Mental dissolution may result from the inability to satisfy or compromise the warring elements and as a result there is engendered the feeling of fear guilt or inferiority, which lie at the root of mental disorders. The whole of life is motivated by the dynamic force of the instincts, which have also been termed the 'mainsprings of volition' hence a man's conduct is only a masquerade of his instincts.

Disorders of Instinct.

The instincts may be exalted, deficient, or perverted. (a) Exaltation occurs in mania, general paralysis, epilepsy. alcoholism, and paranoia. Owing to the loss of inhibition patients give free play to their impulses specially the sexual ones. They become indecent in speech and habits and especially in senile cases, make assaults on the opposite sex. (b) Deficiency occurs in melancholia, and dementia. Self-preservation is lost most, hence suicide and refusal of food is common among depressed patients. (c) Perversion is met most commonly in dementia praecox. This disorder is largely the result of the persistent misapplication of instincts (Meyer). In the Katatonic stage, negativism, stereotypy, mannerisms, and automatic obedience are examples of the instincts "gone astray"!.

Volition.

This is one of the highest faculties of the mind. The "will" is character in action. By it we deliberate and determine upon a line of conduct in a situation where there is apparently no conflict between the sentiments aud emotions. Our actions are the outcome of our own strivings, and the subjective feeling is

that we are free in our decisions. The act of volition is in harmony with the momentary aims of the psyche. We do what we wish because we wish what we do. The universal belief that man possesses a free will of which he is master was rudely shaken by Freud's doctrine of psychic determinism. According to him free will is an illusion and our behaviour is governed by forces and experiences of which we are mainly unconscious. Volition is therefore not free but determined by a number of factors such as heredity, education, instincts, and unconscious wishes.

We are victims not of an external fate but of an internal compulsion, a dynamic force the origin of which lies outside our own experience, in the unconscious. Our motives are derived from the sum of racial experience born within us part of our hereditary equipment and are also influenced by apperception. Volition becomes undermined or weak if the sentiment of self-regard is destroyed. This often is seen in an alcoholic or drug addict. The beach-comber is an extreme type of man who has lost self respect and therefore has no "will of his own". When action occurs in the absence of deliberation and control it is said to be impulsive but even here this mode of response to a percept or idea may be primarily instinctive. Whether our motives be conscious or unconscious, purposive behaviour is directed towards the fulfilment of a wish. The wish is the dynamic basis of life and is the channel through which life's libido flows towards the ultimate goal of some satisfaction, which comes from avoiding pain and seeking pleasure. Consciousness is not the source of will but an aspect of expression of it.

Disorder of volition.

The will may be (1) Excessive. Hyperbulia is found in mania, excited states, alcoholism, paranoia, in certain cases of

imbecility and in idiots savants. (2) Diminished. In melancholia. Katatonic stupor, psychasthenia, hysteria and mental deficiency, (3) Perverted. This takes the form of mannerisms, stereotypy. morbid impulses and habits, negativism, repetition of words or actions, all of which are seen mainly among patients suffering from dementia praecox, and in some confusional states. Apraxia is a special variety of volitional defect seen in senility, alcoholism and lesions of the corpus callosum. It is said to be agnostic when there is inability to recognise an object, ideomotor, when the patient recognises or names the object but does not know how to use it, or what it is used for. Echopraxia is the imitation of movements of others.

Attention.

McDougall defines attention as "merely conation or striving considered from the point of view of it's effects or cognitive processes". The more fully we strive to achieve better cognition the more attentive we are. Stoddart's definition is that 'attention is that process by which the organism is placed in the attitude best adapted for the reception of stimuli arising from an object attended to or noticed, whereby the perception of such an object becomes clearer and more distinct in consciousness'. Consciousness is fully directed to the object attended to, subject to the amount of affectivity the object possesses for the subject. If we wish to concentrate on a certain theme, we call to our assistance all appropriate associations and exclude the others. Hence everything relevant is observed and considered while the irrelevent is excluded. Attention being a manifestation of affectivity, is governed by the amount of interest we possess for a particular percept. To have an interest in any object is to pay attention to it. Interest is latent attention and attention is interest in action. We are interested only in those things that evoke in us one or

more of the instinctive impulses. If attention is directed by the will it is active, if by external occurances it is passive. An unconscious form of attention is association readiness. If some thing occupies us affectively, then every associated experience will remind us of it, for example, a person who is afraid of being arrested will easily be frightened by any one who might in some way remind him of the police.

The conditions that govern the attraction of attention are.

(1) Change in the environment

(2) Repetition of a stimulus

(3) The intensity and extensity of a stimulus.

Disorder of attention.

(1) Exaltation of or increased attention. Hyperprosexia This occurs in acute mania. Every object in the subject's vision is attended to and from this, ideation is rapid, producing a 'flight of ideas' as evidenced by the jumbled disconnected conversation. It also occurs in katatonic excitement and the manic form of general paralysis. (2) Aprosexia or diminution of attention occurs in melancholia, stuporose states, dementia praecox, frontal lobe lesions, and in mental deficiency. In obsessional states attention becomes automatic.

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APPENDIX

Extracts from the Indian Lunacy Act, 1912.

Reception of Patients.

Section 4 (1) No person other than a criminal lunatic or a lunatic so found by inquisition shall be received or detained in an asylum without a reception order save as provided by section 8, 16 and 18.

Provided that any person in charge of an asylum may with the consent of two of the visitors of such asylum which consent shall not be given except upon a written application from the intending boarder, receive and lodge as a boarder in such asylum any person who is desirous of submitting himself to treatment.

(2) A boarder received in an asylum under the proviso to sub-section (1) shall not be detained in the asylum for more than 24 hours after he has given to the person in charge of the asylum notice in writing of his desire to leave such asylum.

Reception order on Petition.

Section 5 (1) An application for a reception order shall be made by petition accompanied by a statement of particulars to the Magistrate within the local limits of whose jurisdiction the alleged lunatic ordinarily resides, shall be in the form prescribed and shall be supported by two medical certificates on separate sheets of paper one of which certificate shall be from a medical officer.

Section 6 (1) The petition shall be presented if possible by—

(a) The husband or wife of the alleged lunatic;

(b) by any other relative.

(2) If the petition is not presented it shall contain a statement of the reasons why it is not so presented, and of the connection of the petitioners with the alleged lunatic, and the circumstances under which he presents.

Reception order otherwise than on petition.

Sec. 12. When any European who is subject to the provisions of the Army Act has been declared a lunatic in accordance with the provisions of the military regulations in force for the time being, and it appears to any administrative medical officer that he should be removed to an asylum, such administrative medical officer may if he thinks fit make a reception order under his hand for the admission of the said lunatic into an asylum which has been duly authorised for the purpose by the Governor General in Council.

Note—The above section refers to British officers and soldiers who may be admitted to a civil mental hospital. There being no military mental hospitals in India the above class of patients are usually transferred to the United Kingdom as soon as transport is arranged and the patient is fit to travel.

The wives and families of British officers and soldiers are not governed by section 12 of the Indian Lunacy Act or any military regulation as to admission but are treated as civilians and their admission may be effected under section 5 of the Indian Lunacy Act.

In the case of Indian Sepoys or others subject to the Indian Army Act, who become insane, they are first discharged from the army under para 658 A.R.I. Vol. II and subsequently admitted to a mental hospital under the orders of a magistrate exactly as in the case of civilians.

Sec. 13. (1) Every officer in charge of a police station may arrest or cause to be arrested all persons found wandering at large within the limits of his station whom he has reason to believe to be lunatics,..... or to be dangerous by reason of lunacy.

Sec. 14. Whenever any person is brought before a magistrate under the provisions of sub-section (1) of Section 13, the magistrate shall examine such person and if he thinks that there are grounds for proceeding further, shall cause him to be examined by a medical officer, and may make such other inquiries as he thinks fit and if the Magistrate is satisfied that such person is a lunatic and a proper person to be detained he may if the medical officer who has examined such person gives a medical certificate with regard to such person, make a reception order for the admission of such lunatic into an asylum:

Sec. 16. (1) When any person alleged to be a lunatic is brought before a magistrate under the provisions of section 13 or section 15, the magistrate may, by a order in writing, authorise the detention of the alleged lunatic in suitable custody for such time not exceeding ten days as may be in his opinion, necessary to enable the medical officer in respect of whom a medical certificate may be given.

(2) The Magistrate may from time to time, for the same purpose by order in writing, authorize such further detention of the alleged lunatic for periods not exceeding ten days at a time as he thinks necessary—provided that no person shall be detained in accordance with the provisions of this section for a total period exceeding thirty days from the date on which he was first brought before the magistrate.

Medical certificate.

Sec. 18. (1) Every medical certificate under this act shall be made and signed by a medical practitioner or a medical officer, as the case may be, and shall be in the form prescribed.

(2) Every medical certificate shall state the facts upon which the person certifying has formed his opinion that alleged lunatic

is a lunatic, distinguishing facts observed by himself from facts communicated by others, and no reception order on petition shall be made upon a certificate founded only upon facts communicated by others.

(3) Every medical certificate made under this act shall be evidence of the facts therein appearing and of the judgement therein stated to have been formed by the person certifying on such facts, as if the matters therein appearing had been verified on oath.

Sec. 19. (1) A reception order required to be passed on a medical certificate shall not be made unless the person who signs the medical certificate or where two certificates are required each person who signs a certificate has personally examined the alleged lunatic, in the case of an order on petition not more than seven clear days before the date of the presentation of the petition, and in all other cases, not more than seven clear days before the date of the order.

(2) Where two medical certificates are required a reception order shall not be made unless each person signing a certificate has examined the alleged lunatic separately from the other.

Discharge of lunatics

Sec. 31. (1) Three of the visitors of any asylum, of whom one shall be a medical officer, may by order in writing direct the discharge of any person detained in such asylum and such person shall thereupon be discharged:

Provided that no order under this sub-section shall be made in the case of a person detained under a reception order under section 12, or in the case of a criminal lunatic, otherwise than as provided by section 30 of the Prisoners Act 1900.

Sec. 32. (1) A lunatic detained in an asylum under a reception order made on petition shall be discharged if the person on whose petition the reception order was made so applied in writing to the person in charge of the asylum :

Provided that no lunatic shall be discharged under the provisions of subsection (1) if the officer in charge of the asylum certified in writing that the lunatic is dangerous and unfit to be at large.

Escape and Recapture

Sec. 36. Every person received into an asylum under any such order as is required by this act may be detained therein until he is removed or discharged as authorised by law and in case of escape may by virtue of such order, be retaken by any police officer or by the person in charge of such asylum or any officer or servant belonging thereto or any other person authorised in that behalf by the said person in charge and conveyed to and received and detained in such asylum.

Provided that in the case of a lunatic not being a criminal lunatic or a lunatic in respect of whom a reception order has been made under section 12, the power to retake such escaped lunatic under this section shall be exerciseable only for a period of one month from the date of his escape.

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